Supreme Court, U.S.
FILED
FEB 1 1986
JOSEPH F. SPANIOL, JR.
CLERK

No. 85-632

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1985

CHARLES ATKINS, Commissioner
of the Massachusetts
Department of Public Welfare,

Petitioner,

v.

SANTOS RIVERA, Madeline McKenna,
and all others similarly situated,

Respondents.

On Writ of Certiorari
to the Supreme Judicial Court for
the Commonwealth of Massachusetts

BRIEF FOR THE PETITIONER

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January 1986

QUESTION PRESENTED

Whether Massachusetts' use of a six-month spenddown period for medically needy Medicaid eligibility, which has been authorized by federal regulation consistently since the inception of the Medicaid program in 1966 and also is employed by most states which extend Medicaid coverage to the medically needy, violates Title XIX of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982.

PARTIES

The respondent class is composed of all AFDC-related medically needy applicants for or recipients of Medicaid in Massachusetts subject to a six-month spenddown. All other parties are named in the caption.

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BRIEF FOR THE PETITIONER

OPINIONS BELOW

The opinion of the Supreme Judicial Court (Pet. A1) is reported at 395 Mass. 189 and 479 N.E.2d 639. The opinion of the state trial court (Pet. A28) and the administrative decisions of the state

Department of Public Welfare (Pet. A46, A54) are not reported.

JURISDICTION

The jurisdiction of this Court rests upon 28 U.S.C. § 1257(3). The order (Pet. A61) and rescript of the Supreme Judicial Court, the highest court of the Commonwealth of Massachusetts, were entered on June 12, 1985. J.A. 5-6. On August 21, 1985, Justice Brennan extended the time in which to petition for certiorari to October 15, 1985 (Supreme Court docket no. A-147). The Commissioner's petition for rehearing in the Supreme Judicial Court was denied on September 26, 1985. Pet. A63; J.A. 7. The petition for certiorari was filed on October 11, 1985, and was granted on December 9, 1985.

STATUTES INVOLVED

This case involves the construction of 42 U.S.C. § 1396a(a)(10)(C)(i)(III) (1982 ed.), inserted by the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, § 137(b)(8), 96 Stat. 378, which provides that a State choosing to extend Medicaid coverage to medically needy groups must, in its state plan, describe:

> (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups; . . . (emphasis added)

The decision below held that the emphasized language requires a one-month "spenddown" in determining medically needy Medicaid eligibility and, on that ground, held invalid Mass. Gen. Laws ch. 118E, § 10, fourth unnumbered paragraph (1984 ed.), which provides:

> In any case where the monthly income of a recipient or beneficiary is in excess of the exemptions allowed, the recipient or beneficiary shall be liable to pay to the provider of medical care or service an amount which shall be equal to the excess income for a period of six consecutive months, which includes the period when such service was provided. (emphasis added)

The spenddown concept derives from 42 U.S.C. § 1396a(a)(17), which provides that the state Medicaid plan must:

> include reasonable standards . . . for determining eligibility . . .; and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the

> Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law[.] (emphasis added)

42 C.F.R. § 435.831 (1985) provides:

> The [state Medicaid] agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income. . . . (emphasis added)

The full text of these and other relevant statutes and regulations is set forth in the appendix to this brief.

STATEMENT OF THE CASE

1. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., was enacted in 1965 to enable states, "as far as practicable under the conditions in such State," to provide medical assistance ("Medicaid") to needy families with

children and aged, blind or disabled individuals. 42 U.S.C. § 1396. Participating states must provide coverage to all those who receive cash assistance under either of the two major federal categorical welfare programs: Aid to Families with Dependent Children (AFDC), 42 U.S.C. §§ 601 et seq.; and Supplemental Security Income (SSI), 42 U.S.C. §§ 1381 et seq. See 42 U.S.C. § 1396a-(a)(10)(A)(i).[1/] These groups are referred to as the "categorically needy." 42 C.F.R. § 435.4 (1985). Congress required such coverage for participating

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1/ The so-called "§ 209(b) option" creates an exception to this requirement as to SSI recipients in states which choose to use instead the standards of their former categorical assistance plans for the aged, blind and disabled as of January 1, 1972. See 42 U.S.C. § 1396a(f); Schweiker v. Gray Panthers, 453 U.S. 34, 37-39 (1981). Massachusetts is not a § 209(b) state.

states because "[t]hese people are the most needy in the country and it is appropriate for medical care costs to be met, first, for these people." H.R. Rep. No. 213, 89th Cong., 1st Sess. 66 (1965).[2/]

A participating state also has the option of extending coverage to other, "less needy," groups, id., who are referred to as the "medically needy" -- families and individuals who would qualify for AFDC or SSI except for their income or resources, but whose income and resources are insufficient to meet the costs of necessary medical and remedial care and services. 42 U.S.C. § 1396a(a)-

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2/ Eligibility for the categorical programs of cash assistance is determined on a monthly basis. See 42 U.S.C. §§ 602(a)(13) (AFDC); 42 U.S.C. § 1382(c)(1) (SSI).

(10)(C); 42 C.F.R. § 435.4.[3/] See generally, Schweiker v. Hogan, 457 U.S. 569, 571-76 (1982).

Massachusetts has chosen to participate in Medicaid and to extend coverage to the "medically needy". Mass. Gen Laws ch. 118E, § 1 (1984 ed.).[4/]

3/ The 1981 amendment to 42 U.S.C. § 1396a(a)(10)(C)(i) appears to some extent to have relaxed the link between the definition of the medically needy and the underlying categorical programs. See pp. 40-41, infra (detailing the statutory change); but see 42 U.S.C. § 1396a(a)(10)(C)(ii) (1982 ed.).

4/ For the Court's convenience, the petitioner is lodging with the Clerk copies of relevant portions of the state Medicaid financial eligibility regulations, 106 Code of Massachusetts Regulations ("C.M.R."), Parts 505 and 506. The principal relevant spenddown regulations are also reproduced in the Appendix to this brief.

Massachusetts determines financial eligibility for a medically needy applicant in a straightforward manner.[5/] First, gross countable income is calculated.[6/] Then, various deductions are subtracted, to determine the applicant's

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5/ The references in the following discussion apply to applicants other than those who are in long-term institutional care. Different rules in certain respects apply to institutional residents, due to their unique situation. See R. 162-63 (HHS explanation); Williams v. St. Clair, 610 F.2d 1244 (5th Cir. 1980) (upholding the anticipation of medical costs for such persons). These differences have never been involved in this litigation and are immaterial to the issue presented.

6/ See 106 C.M.R. §§ 505.200 (Income), 505.210 (Countable Earned Income) 505.220 (Countable Unearned Income). Some income that is actually received is not counted in determining eligibility. Id. § 505.230 (Non-Countable Income).

net countable income. 42 C.F.R. § 435.831(a).[7] The net countable income figure is then compared with the Medicaid income standard.[8] If the applicant's net countable income is equal to or less than the income standard, the applicant is eligible for Medicaid coverage. 42 C.F.R. § 435.831(b); 106 C.M.R. § 506.400.[9]

7/ See 106 C.M.R. §§ 506.110 (Unearned Income Deductions), 506.120 (Earned Income Deductions), 506.130 (General Income Deductions).

8/ This is the "single [income] standard" of 42 U.S.C. § 1396a(a)(10)(C)(i)-(III). See 106 C.M.R. § 506.410.

9/ It is uncontested that in this process of determining countable income for measurement against the Medicaid income standard, Massachusetts uses the same methodology which would be employed in determining the applicant's eligibility for the most closely related categorical program, i.e., AFDC for the respondent class in this case, and SSI for the SSI-related medically needy class in Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985).

The respondents do not qualify for Medicaid on this basis, however, because their net countable income exceeds the Medicaid income standard. The determination of their Medicaid eligibility involves an extra factor, not considered for categorically needy eligibility: they may become eligible if they incur medical expenses equal to their "excess income" (i.e., the amount by which their net countable income exceeds the Medicaid income standard). 42 U.S.C. § 1396a(a)-(17); 42 C.F.R. § 435.831(c)-(d); 106 C.M.R. §§ 506.500 et seq. The amount of medical bills that must thus be incurred is known as a "spenddown."10/

10/ This term is somewhat misleading. The applicant is only required to incur the expense, and need not have actually paid the bill for medical services. 42 U.S.C. §§ 1396a(a)(17), 1396b(f)(2); 42 C.F.R. § 435.831(c)-(d); 106 C.M.R. § 506.540.

2. The Secretary of Health and Human Services ("HHS"), and before him the Secretary of Health, Education and Welfare ("HEW"), have permitted a spenddown period of up to six months since the inception of the Medicaid program in 1966.[11/] In reliance upon the Secretary's regulations, 25 of the 32 jurisdictions participating in the medically needy program at the time of the TEFRA amendment at issue in this case used a spenddown period of greater than one

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11/ Department of Health, Education and Welfare, Handbook of Public Assistance Administration, Supplement D, Section D-4220(A)(4) (June 17, 1966), now codified at 42 C.F.R. § 435.831 (1985) (both reproduced in the Appendix to this brief); see DeJesus v. Perales, 770 F.2d 316, 322-23 and n. 8 (2d Cir. 1985); Hogan v. Heckler, 769 F.2d 886, 893 (1st Cir. 1985); see also n. 33, infra.

month.[12] Twenty used six months.[13]

Massachusetts is one of those states. Mass. Gen. Laws ch. 118E, § 10, fourth unnumbered paragraph, inserted by Mass. St. 1969, c. 800, requires the calcula-

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12/ These figures are derived from interrogatory answers filed by the Secretary in October 1983 in Hogan v. Heckler, No. 80-883-T (U.S.D.C., D. Mass.), which were submitted below in this case at the summary judgment stage and are reproduced at R. 152-168; see esp. R. 168 (table). The petitioner is unaware of any changes between the enactment of TEFRA in September 1982 and the date of this document (except the adoption by the State of Washington of multiple budget periods, see R. 161). Several states have adopted medically needy programs more recently. See n. 29, infra.

13/ Two of the 20, however, afforded the recipient a choice between six months and either one month (Illinois) and three months (Washington). R. 168. Although Nebraska is also listed as having multiple periods, this was not at the recipient's option; the one-month period applied only to a limited category of individuals. See R. 161.

tion of excess income over a six-month period to arrive at the spenddown amount. See 106 C.M.R. §§ 506.510, 506.520 (implementing this statutory command).[14/] Once the applicant incurs medical bills equal to the amount of the spenddown, Medicaid pays for all other covered services during the spenddown period. See 106 C.M.R. § 506.570.[15/]

3. Ms. Rivera applied for Medicaid on January 13, 1983. Pet. A50. A hearing officer determined after an administrative hearing (R. 20-75) that her net

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14/ Massachusetts regulations more generally provide for the use of six-month budget period, see 106 C.M.R. § 505.300, although income is converted to monthly amounts before being used in eligibility calculations, id. § 505.320.

15/ If the applicant's income changes during the six-month period, adjustments are made accordingly. 106 C.M.R. § 506.560.

countable income was $535.30 per month. Pet. A51.[16] At that time the standard of need for a family of 3 (Ms. Rivera and her 2 children) was $435 per month;[17] Ms. Rivera thus had income of $100.30 per month in excess of the income standard. Pet. A51. It followed that she had a six-month spenddown liability of $601.80 (6 x $100.30). J.A. 19 (Complaint, ¶ 25); Pet. A51. But she argued that the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, § 137(b)(8), 96 Stat. 378,

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16/ The findings of fact by the administrative hearing officer are final unless unsupported by substantial evidence. Mass. Gen. Laws ch. 30A, § 14. In this case, the administrative findings (see Pet. A50-A51, A57-A59) were not disputed in the Superior Court.

17/ The applicable standard has since been increased. The current level is set forth in 106 C.M.R. § 506.410 (December 1985).

required her spenddown to be calculated on a monthly basis. R. 40-42. Ms. Rivera claimed that the Department should pay the difference between her excess income for one month ($100.30) and medical bills incurred in that one month totalling $314.00. J.A. 19 (Complaint, ¶ 26).[18]

Under the six-month spenddown, Ms. Rivera and persons similarly situated must budget the payment of medical expenses over a period longer than one month, up to an amount equalling six months' excess income. The six-month

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18/ The intervenor-plaintiff, Ms. McKenna, unlike Ms. Rivera, had regular dental expenses of $70 a month (with no other medical expenses) which were less than her excess income of $106.66 a month. See R. 96-97; J.A. 40-43. For this reason, her eligibility would not appear actually to have been affected by the length of the spenddown period applied to her.

spenddown focuses the state's resources instead upon another group of applicants who are in greater need. An applicant whose excess income is $100/month and whose medical expenses exceed $600 in a six-month period is more needy than another applicant (such as Ms. Rivera) with the same income but with medical expenses of only $314 over six months -- even if the entire $314 happens to be incurred in one month. In short, the six-month spenddown allocates scarce welfare resources to the neediest of potentially eligible applicants.[19/]

19/ Massachusetts couples this policy with a high standard of income eligibility and a wide range of covered medical services. See Department of Health and Human Services, Medicare and Medicaid Data Book, 1981 (April, 1982) at 78, 105, 106, 111; Committee Print No. 10, 95th Cong., 1st Sess., "Data on the Medicaid Program: Eligibility, Services, Expenditures, Fiscal Years 1966-77," at 6, 9, 86-87.

4. The complaint was brought in May 1983 in the Massachusetts Superior Court against the Massachusetts Commissioner of Public Welfare ("Commissioner"), as a class action challenging the use of a six-month spenddown as violative of Title XIX. J.A. 8-24. The trial court certified a plaintiff class of AFDC-related medically needy applicants for or recipients of Medicaid subject to a six-month spenddown. Pet. A34-A35. The case was presented on summary judgment, both parties agreeing that there were no material facts in dispute. See Pet. A8.[20/] The trial court held that the six-month

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20/ The plaintiffs' Motion for Summary Judgment is set forth at J.A. 54. The Commissioner argued for judgment in his favor pursuant to Mass. R. Civ. P. 56(c) ("Summary judgment, when appropriate, may be rendered against the moving party.").

spenddown violated the "same methodology" requirement of TEFRA, because AFDC eligibility is determined on a monthly basis. Pet. A40-A42.[21]

The Supreme Judicial Court affirmed. After considerable attention to another issue,[22] that court addressed and invalidated the six-month spenddown in two paragraphs. Pet. A23-26. Essentially, the state's highest appellate court relied upon the analysis of Hogan v.

21/ The Amended Judgment, entered on May 24, 1984, declared the six-month spenddown provision of Mass. Gen. Laws ch. 118E, § 10, to be void pursuant to the Supremacy Clause and permanently enjoined the use of a spenddown period of longer than one month. Pet. A66 (¶ 4), A67 (¶ 6).

22/ Whether the failure to deduct payroll withholdings from earned income in calculating Medicaid eligibility violated state law -- the court found that it did not. Pet. A61, A10-A23; see J.A. 5-6.

Heckler, 597 F. Supp. 1106 (D. Mass. 1984), a federal trial court decision which has since been reversed by Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985). The court's substantive analysis was limited to the assertions that "the length of the spenddown period is part of the methodology for evaluating income eligibility," Pet. A24 (quoting 597 F. Supp. at 1110), and that the use of a six-month spenddown for medically needy eligibility is more restrictive than the one-month budget period used for the categorically needy, allegedly in violation of the intent of TEFRA as evidenced by a statement in subsequent legislative history. Pet. A25-26. The court "affirm[ed] that portion of the [Superior Court] judgment which determined that the department's use of a six-month budget period for

spend down purposes violated 42 U.S.C. § 1396a(a)(10)(C)(i)(III)." Pet. A26-27. The rescript so ordering entered on June 12, 1985. J.A. 5-6; Pet. A61-A62.

On August 12, 1985, Hogan v. Heckler, 769 F.2d 886 (1st Cir. 1985), and DeJesus v. Perales, 770 F.2d 316 (2d Cir. 1985), were decided -- both in direct conflict with the decision below. In order to bring these intervening authorities to the attention of the Supreme Judicial Court prior to seeking review in this Court, the Commissioner sought and received an extension of time in which to petition for certiorari, and filed a petition for rehearing, see J.A. 6, but the Supreme Judicial Court denied rehearing, without opinion, on September 26, 1985. J.A. 7; Pet. A63.

SUMMARY OF ARGUMENT

Massachusetts' use of a six-month spenddown for medically needy Medicaid eligibility is firmly grounded in a long-standing HHS regulation, which is entitled to deference. The "same methodology" requirement of 42 U.S.C. § 1396a(a)-(10)(C)(i)(III), inserted by the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, § 137(b)(8), 96 Stat. 378, did not interdict this practice, which is employed by most states extending Medicaid coverage to medically needy; the legislative history shows clearly that in enacting this TEFRA amendment Congress did not intend to override, but instead expressly reaffirmed, the HHS regulation authorizing it.

A. The plain language of the TEFRA amendment does not encompass the spend-

down determination. The concept of offsetting medical expenses against income, the creation of 42 U.S.C. § 1396a(a)(17), is unique to the medically needy. Neither AFDC nor SSI has any "methodology" for a spenddown of medical expenses. The statute cannot mean that the spenddown determination, the flexible accounting for medical expenses against income, should be conducted by the "same methodology which would be employed" in determining the applicant's eligibility for AFDC or SSI, since those programs recognize no spenddown adjustment at all.

B. This statutory language was enacted as a "Technical Correction", with no hint in the legislative history that either its purpose or effect was to force 23 states and the District of Columbia to substantially expand the scope of

their medically needy programs by requiring a one-month spenddown.

Rather, Congress had something else very specifically in mind -- the rules for evaluating items of income -- when it enacted this language. The legislative history is clear that the phrase was inserted for the particular purpose of correcting a 1981 HHS regulatory amendment not involving the length of a spenddown. That 1981 HHS amendment, promulgated to implement the Omnibus Budget Reconcilation Act of 1981 ("OBRA"), P.L. 97-35, § 2171(a), 95 Stat. 807, had interpreted OBRA to give the states flexibility in evaluating certain types of income; the "same methodology" requirement was intended to reinstate the use of particular cash assistance program methodologies in that area. See H.R. Rep. No. 97-757, Part I, 97th Cong., 2d

Sess. 13 (1982). Congress expressly stated its intent to reinstate the prior regulatory scheme, and specifically reaffirmed certain HHS regulations which antedated OBRA, including the one which has always permitted a six-month spenddown period. Id.

In requiring a State to determine Medicaid eligibility in the same manner that was used prior to the recent series of amendments, the "same methodology" language clearly does not interdict the continued use of a six-month spenddown. In Massachusetts, this practice has been in effect since at least 1969. The federal policy permitting it was adopted by the Department of Health, Education and Welfare in 1966 and was incorporated in the first Medicaid regulations in 1969. That policy and practice have been con-

sistently maintained, both prior to and following OBRA. It is inconceivable that Congress intended to prohibit this widespread and important practice by adopting a "technical correction from OBRA" while expressly endorsing the longstanding HHS authorizing regulation.

C. The Secretary's consistent regulation, currently set forth at 42 C.F.R. § 435.831, originally adopted in 1966 pursuant to the express delegation of authority by Congress in 42 U.S.C. § 1396a(a)(17), is entitled to deference -- indeed, to legislative effect. By this regulation, and by the approval of numerous State plans, the Secretary has consistently authorized a six-month spenddown at all times before, during and after the recent series of congressional amendments, and Congress has never

questioned that interpretation. Since it is clearly within the scope of the Secretary's authority and is based upon a reasonable interpretation of Title XIX, it should be given controlling weight.

D. Nor is the Secretary's regulation authorizing six-month spenddowns invalid by virtue of the "comparability" requirement of 42 U.S.C. § 1396a(a)(17), which is irrelevant to the spenddown determination. Even if that provision extends to comparability between the categorically needy and the medically needy, which is very doubtful, the statute does not require such comparable treatment in all respects. Schweiker v. Hogan, 457 U.S. 569, 587 (1982). The flexible offset of medical expenses against income is one of the major distinguishing features between the categorically and the medically

needy. The fundamental difference in this aspect of financial eligibility forecloses any possibility that the "comparability" requirement is violated by a six-month spenddown.

ARGUMENT

MASSACHUSETTS' SIX-MONTH SPENDDOWN, WHICH WAS ADOPTED AND IS MAINTAINED PURSUANT TO A LONGSTANDING FEDERAL REGULATION, DOES NOT VIOLATE TITLE XIX AS AMENDED BY TEFRA.

A. The "Same Methodology" Language Has No Application to the Spenddown Determination, An Extra Step Unique to Medicaid.

This case involves the construction of 42 U.S.C. § 1396a(a)(10)(C)(i)(III), inserted by the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, § 137(b)(8), 96 Stat. 378. That section applies to states, like

Massachusetts, which choose to extend Medicaid coverage to the medically needy. It requires the state, in determining "income . . . eligibility" of the medically needy under a "single standard," to use the "same methodology which would be employed," in the case of the plaintiff class, for determining their AFDC eligibility. In fact, the income of the plaintiff class in this case is calculated by Massachusetts according to the "same methodology" which would be employed for determining their AFDC eligibility, and then is measured against the "single standard" -- the medically needy income standard -- for determining their Medicaid income eligibility. See 42 C.F.R. § 435.831(b). In each case the applicant was found ineligible for Medicaid. Section 1396a(a)(10)(C)(i)(III)

requires no more. See DeJesus v. Perales, 770 F.2d 316, 326 (2d Cir. 1985).

Only thereafter does the state turn to the extra step of offsetting incurred medical expenses against excess income, a step provided by § 1396a(a)(17) (final clause). Neither the AFDC program nor the SSI program has any "methodology" for such a computation, since this offsetting concept is unknown to either program. In both cash assistance programs, net income is measured against a set income standard with no adjustment for medical expenses. In both programs the applicant or recipient's medical expenses are not taken into account in any way. It is, therefore, meaningless to suggest that the state, in taking into account medical expenses against excess income for the Medicaid program, must use the

"same methodology" as it uses for calculating AFDC or SSI eligibility. DeJesus v. Perales, 770 F.2d at 327.

The court below asserted that "the length of the spenddown period is part of the methodology for evaluating income eligibility." Pet. A24. The assertion that the word "methodology" is broad enough to encompass the length of the spenddown period, however, does not end the inquiry. In initiating the use of "methodology" in this context, HHS used it much more narrowly, referring to "such matters as deemed income, interest, court-ordered support payments, and infrequent and irregular income." 46 Fed. Reg. 47980 (Sept. 30, 1981) (quoted in context at p. 44, infra). Since Congress' use of the term in TEFRA was in direct response to that HHS initiative,

see pp. 45-46, infra, it is likely that Congress adopted the same restricted meaning. See Hogan v. Heckler, 769 F.2d 886, 901 (1st Cir. 1985).

Moreover, in concluding otherwise, the court below ignored or misapprehended the meaning and the objective of the complete statutory phrase -- "same methodology which would be employed under the appropriate State plan."[23/] Even accepting, arguendo, the abstract possibility that Congress could have used the word "methodology" in the statute more broadly than HHS had used it, consideration of the statutory phrase taken as a whole makes it clear that Congress did

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23/ In this case, the appropriate State plan is the AFDC plan. The language of the statute as it applies to the SSI-related medically needy is parallel. See p. 3, supra.

not in fact do so. The conclusion of the court below would make sense only if the qualifying statutory phrase ("which would be employed . . .") were directed to what length of spenddown period would be employed in the state's AFDC plan *if AFDC had a spenddown*. But this question, the answer to which is speculative in any event,[24/] is inapposite. Congress in plain language clearly was referring instead to a different situation, *viz.*, what methodologies would be employed *if the applicant had applied instead for AFDC*. The statute specifically refers to the methodologies "which would be employed under the appropriate State plan,"

24/ Although AFDC eligibility is determined on a monthly basis, the potential expansion inherent in the addition of a spenddown component might well lead to a different period for that aspect.

in this case the AFDC plan.[25/] The answer to that question indisputably is that no spenddown -- over any period -- would be recognized.

If Congress had intended to impose a requirement that the length of the medically needy spenddown period must be the same as the AFDC budget period, Congress could and surely would have said so. This is particularly true in light of the fact that such a requirement would have invalidated an important component of the State plans of 25 out of the 32 jurisdictions extending Medicaid coverage to the medically needy at that time.

25/ As will be noted below, the purpose of TEFRA's insertion of the "same methodology" requirement was precisely to reinstate actual AFDC (and SSI) methodologies for the evaluation of certain types of income.

"It will not be presumed that a federal statute was intended to supersede the power of the State unless there is a clear manifestation of intention to do so." New York Department of Social Services v. Dublino, 413 U.S. 405, 413 (1973). It is certainly not manifest that the phrase "same methodology which would be employed under the appropriate State plan" has any application to the spenddown determination, a determination unknown to any appropriate State plan.

Instead, the language which Congress used is so limited that it clearly cannot apply to the spenddown determination. Congress cannot possibly have intended the spenddown calculation to be conducted by the "same methodology which would be employed" for determining AFDC (or SSI) eligibility, since the offsetting of med-

ical expenses is an extra step, unique to the medically needy program.

B. The "Same Methodology" Language Was Intended To Do No More Than To Reinstate the Pre-OBRA Regulatory Scheme, Under Which Six-Month Spend-downs Abounded.

In ascertaining the intent of Congress in enacting this TEFRA amendment, it is essential to consider the legislative history. DeJesus v. Perales, 770 F.2d 316, 324 (2d Cir. 1985). See generally, Train v. Colorado Public Interest Research Group, 426 U.S. 1, 9-10 (1976); 2A N.J. Singer, Sutherland Statutory Construction § 48.01 (4th ed. 1984).

The "same methodology" language was added by the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), P.L. 97-248, § 137(b)(8), 96 Stat. 378. At

that time, out of 32 jurisdictions providing medically needy coverage, 25 used spenddown periods of greater than one month. R. 168; n. 12, supra. Federal law then (as now) required both SSI and AFDC eligibility to be determined on a monthly basis. See 42 U.S.C. §§ 602(a)-(13), 1382(c)(1) (1982 ed.). If the "same methodology" language was meant to require the length of a spenddown period to be the same, as the court below ruled, this TEFRA amendment represented a very substantial increase in the coverage of the medically needy programs in 23 states[26/] and the District of Colum-

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26/ Excluding one state, Illinois, since it is listed at R. 168 as also providing a one-month alternative. Although the respondents' theory would invalidate the six-month component, it would not appear to increase Illinois' coverage if a one-

(footnote continued)

bia.[27/] Under such circumstances, it might be anticipated that the amendment would receive significant attention in

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(footnote continued)

month option is already available. Of the other two states listed at R. 168 as having multiple spenddowns, neither of Washington's alternatives would survive, and Nebraska's one-month alternative is limited, see R. 161.

27/ The expansion of the Medicaid program from the imposition of a one-month spenddown would be dramatic. The state projected below that the increased payments in its AFDC-related medically needy program (which expended $47.8 million in fiscal year 1983) would be $19.6 million in the first year alone, R. 186, ¶ 12, with the potential for a substantially greater increase thereafter, see R. 148, ¶¶ 12-13. See also DeJesus v. Perales, 770 F.2d 316, 320 (2d Cir. 1985) ($78 million annually in New York for inpatient hospital care of AFDC-related medically needy alone). The imposition of a one-month spenddown would have a much greater financial impact with respect to the SSI-related medically needy groups, which have considerably greater medical costs since they are composed of elderly and disabled individuals.

Congress. However, quite the contrary was the case.

The notion that TEFRA was intended to result in an expansion of the Medicaid program flies in the face of the overall purpose of that Act, which was to reduce domestic spending in the face of large budget deficits.28/

This amendment in particular was part of a TEFRA section entitled: "Technical Corrections from Omnibus Budget Reconciliation Act of 1981." 96 Stat. 376. And no hint is given in the legislative history that either the purpose or the effect of the technical correction was to

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28/ See generally, Wing, "The Impact of Reagan-Era Politics on the Federal Medicaid Program," 33 Cath. U.L. Rev. 1 (1983). The "same methodology" amendment was part of Title I of TEFRA, which is entitled, "Provisions Relating to Savings in Health and Income Security Programs" (emphasis added). 96 Stat. 324.

force 23 states and the District of Columbia to enlarge the scope of their medically needy programs, or indeed to require any change whatsoever to those programs.

Rather, the legislative history is clear that Congress intended by this provision to do exactly what its title said: to make a technical correction -- more specifically, to correct a 1981 amendment to HHS regulations and to reinstate the earlier regulatory scheme.

Those 1981 HHS changes which TEFRA corrected came about in the following manner. Before the Omnibus Budget Reconciliation Act of 1981 ("OBRA"), P.L. 97-35, § 2171(a), 95 Stat. 807, states participating in the medically needy program were required by 42 U.S.C. § 1396a-(a)(10)(C)(i) to cover:

> all individuals who would, except for income and resources, be eligible for [AFDC or SSI] and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services . . .

Under OBRA's amendment to § 1396a(a)(10)-(C)(i), if coverage was provided to any medically needy group, the state plan was instead required to:

> include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance and (II) the amount, duration, and scope of medical assistance made available to individuals in the group . . .

The purpose of this statutory change was to provide States "with flexibility in establishing eligibility criteria and scope of services within the medically needy program to address the needs of different population groups more appro-

priately." H.R. Rep. No. 208, 97th Cong., 1st Sess. 971, reprinted in 1981 U.S. Code, Cong. & Admin. News 1333.

HHS responded to OBRA by promulgating regulations that provided states with greater flexibility in establishing programs for the medically needy. 46 Fed. Reg. 47976 et seq. (September 30, 1981). For example, the regulations provided for the adoption of medically needy programs applicable to less than all medically needy groups. See 46 Fed. Reg. 47978, amending 42 C.F.R. § 435.301(b).[29/] Unfortunately, how-

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29/ We are informed by HHS that the following states recently have adopted medically needy programs applicable to less than all medically needy groups, with spenddown periods as indicated: Georgia (six months); Iowa (two months); Oregon (six months); South Carolina (six months); and Texas (six months). Tennessee has reduced the scope of its medically needy program correspondingly (retaining its spenddown period of three months, see R. 168).

ever, HHS went beyond the intent of Congress and permitted new flexibility in the area of income and resource eligibility as well. For example, the new regulations permitted different income standards for different medically needy groups. See 46 Fed. Reg. 47979, amending 42 C.F.R. §§ 435.811-435.814.30/ HHS also promulgated several entirely new regulations, 42 C.F.R. §§ 435.850-435.852, which provided primarily and essentially that in determining eligibility of medically needy individuals, states would be permitted to use any methodology for the treatment of income and resources that was reasonable. See

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30/ The statute prior to OBRA had required "comparable standards," but the HHS regulations had required uniformity. TEFRA reinstated this requirement by the "single standard" language of § 1396a(a)-(10)(C)(i)(III). See p. 45-46, infra.

46 Fed. Reg. 47989. HHS explained these provisions as follows:

> States are no longer required to apply a uniform methodology for treating income and resources in such matters as deemed income, interest, court-ordered support payments, and infrequent and irregular income. Rather, the State plan must specify the methodology that will be used; and that methodology must be reasonable. (See 42 CFR 435.850-435.852 and 436.850-436.852, as added by this final rule.)

46 Fed. Reg. 47980 (Sept. 30, 1981).

The TEFRA amendment which added § 1396a(a)(10)(C)(i)(III) was passed in direct response to these HHS regulatory changes. In other words, the HHS changes were the "mischief" to which § 1396a(a)-(10)(C)(i)(III) was directed. As was explained by the House Energy and Commerce Committee in its Report on the amendment:

The 1981 Reconciliation Act gave the States certain specified flexibility in designing their medically needy programs. They are no longer required to cover all eligibility groups, e.g., aged, blind, or disabled persons and families with dependent children. They are no longer required to provide the same benefit package to each group they choose to cover. However, the 1981 Reconciliation Act made no changes in the applicable income and resource eligibility rules.

Unfortunately, the Department, in its interim final rule of September 30, 1981, 46 Fed. Reg. 47976, assumed that the conferees had intended to give the States extensive flexibility in this area as well. This is simply incorrect. When the Statement of Managers of the conference committee report spoke of providing the States "with flexibility in establishing eligibility criteria and scope of services within the medically needy program to address the needs of different population groups more appropriately," (H.R. Rep. 97-208, p. 971), it was referring to the service package and coverage group provisions, not inviting a wholesale rewriting of current income and resource standards

> and methodologies. This amendment makes clear that the Department had no authority to alter the rules that applied before September 30, 1981, with respect to medically needy income levels, medically needy resource standards, and the methodology for treating medically needy income and resources. The Committee bill reaffirms the financial requirements previously in effect for the medically needy (42 C.F.R. sec. 435.800-435.845).

H.R. Rep. No. 97-757, Part I, 97th Cong. 2d Sess. 13 (1982).

This dynamic generating the "same methodology" amendment clearly shows that the congressional intent in enacting that amendment was not to require a change in medically needy programs, but simply to restore the pre-OBRA regulatory scheme, insofar as it concerned financial eligibility. Hogan v. Heckler, 769 F.2d 886, 901 (1st Cir. 1985). The court below appeared to recognize this when address-

ing the other issue before it on the appeal. Quoting the recent congressional reconfirmation that TEFRA "amended the Medicaid statute to clarify that Congress did not intend to change the policies governing the [. . .] eligibility of the medically needy from those in effect before OBRA," H.R. Rep. No. 861, 98th Cong., 2d Sess., 1367 (1984), reprinted in 1984 U.S. Code Cong. & Admin. News 2055, the court concluded: "Our examination of this legislative history indicates that 42 U.S.C. § 1396a(a)(10)(C)-(i)(III) requires a State to determine [Medicaid] eligibility in the same manner that was used prior to the recent series of amendments." Pet. A17-A18.

This understanding, which is entirely correct, leads inexorably to the conclusion that the continued use of a six-month spenddown was not interdicted by

TEFRA. As previously noted, the pre-OBRA HHS regulations authorized, and most participating states pursuant to that authorization then used, six-month spend-downs in their determination of medically needy eligibility.[31/]

31/ However, when the court below turned to this issue it ignored its earlier conclusion. Instead, it misconstrued H.R. Rep. No. 98-861 by citing it for the assertion that Congress intended in TEFRA to prevent more restrictive treatment of the medically needy than of the categorically needy. Pet. A26. The Report (which concerns the subsequent partial moratorium, 98 Stat. 1112, P.L. 98-369, § 2373(c), upon the Secretary's enforcement of the TEFRA amendment) evidences Congressional concern that the Secretary may have overreacted to the TEFRA amendment by prohibiting certain less restrictive practices which had been permitted prior to OBRA, contrary to the Congressional intent in TEFRA to reinstate the practices in effect prior to OBRA. The statement (H.R. Rep. No. 98-861 at 1368) that States "are still foreclosed from being more restrictive than the relevant cash assistance programs" simply points out what is clear on the face of the mor-

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Moreover, the last sentence of the TEFRA Report quoted at pp. 45-46 above is of particular importance for another reason: it specifically "affirm[ed] the

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(footnote continued)

atorium statute, that the moratorium does not apply with respect to practices viewed by the Secretary as being more restrictive, presumably because Congress had no cause for concern (it expressed none) about the Secretary's enforcement in that area. In any event, neither the plain language of TEFRA nor its legislative history supports a "no more restrictive" interpretation; nor does H.R. Rep. No. 98-861 taken as a whole. Finally, even if it were proper to read a "no more restrictive" gloss onto the TEFRA amendment, it begs the question to assert that a six-month spenddown is more restrictive. HHS, which prior to OBRA had required states to use the same rules for determining income eligibility for the medically needy as were used in determining categorically needy eligibility, see 46 Fed. Reg. 47980 (quoted at p. 44, supra), never took the position that the length of the medically needy spenddown was thereby required to be the same as the budget period for the applicable categorical program. See 42 C.F.R. § 435.831.

financial requirements" previously contained in 42 C.F.R. §§ 435.800 - 435.845. This included the Secretary's regulation authorizing the practice challenged in this case of employing a prospective six-month period for the medically needy spenddown determination. In light of the fact that Congress the year before had adopted retrospective, monthly budgeting for both AFDC and SSI eligibility determinations, see OBRA, P.L. 97-35, §§ 2315 and 2341, 95 Stat. 855 and 865 (1981), "[i]t is hard to imagine a clearer indication that Congress did not intend to equate the length of the spenddown period with the length of the budget period used to determine income." Hogan v. Heckler, 769 F.2d 886, 901 (1st Cir. 1985).

Clearly, Congress did not contemplate an expansion of Medicaid coverage when it

enacted this "technical amendment". Its intention was simply to correct an HHS misinterpretation of the OBRA amendments. In so doing, Congress graphically demonstrated its awareness of the HHS regulatory scheme and its readiness to correct HHS when necessary or appropriate. That it did not correct, but instead affirmed, the six-month spenddown regulation makes it clear beyond peradventure that TEFRA was not intended to invalidate the use of a six-month spenddown.

C. The Secretary's Consistent Regulation Authorizing Six-Month Spenddowns Governs this Case.

Title XIX of the Social Security Act is a statute of "unparalleled complexity," DeJesus v. Perales, 770 F.2d 316, 321 (2d Cir. 1985), "among the most in-

tricate ever drafted by Congress." Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981). "Perhaps appreciating the complexity of what it had wrought, Congress conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of the Act." Id.

Such authority with specific reference to medically needy spenddowns was conferred by Congress precisely in the final clause of 42 U.S.C. § 1396a(a)(17), which delineates the spenddown concept: the state plan must -- "provide for flexibility in the application of such standards [for determining eligibility for and the extent of medical assistance under the plan] with respect to income by taking into account, except to the extent prescribed by the Secretary, the

costs . . . incurred for medical care" (emphasis added).[32/]

Pursuant to Congress' authorization, the Secretary of Health and Human Services and before him the Secretary of Health, Education and Welfare has consistently, since the inception of the Medicaid program, sanctioned the use of a spenddown period of up to six months. HEW Handbook of Public Assistance Administration, Supplement D, Section D-4220(A)(4) (June 17, 1966) (reproduced in the appendix hereto).[33/] This

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32/ See also 42 U.S.C. § 1302 (granting to the Secretary the authority to "make and publish such rules and regulations, not inconsistent with" the Act "as may be necessary [for its] efficient administration.").

33/ See also id., § D-4240(A)(3): "Since the income level for maintenance will usually be expressed as 'annual income,' for administrative purposes the

(footnote continued)

authorization was retained in the first set of HEW Medicaid regulations in 1969, 34 Fed. Reg. 1321 (Jan. 28, 1969), codified at 45 C.F.R. § 248.21(a)(4) (1969), and is now set forth in 42 C.F.R. § 435.831 (1985). These regulations "plainly permit" a six-month spenddown. DeJesus v. Perales, 770 F.2d 316, 322 (2d Cir. 1985); Hogan v. Heckler, 769 F.2d at 889, 896.[34/]

(footnote continued)

individual's or family's income will have to be measured on a monthly basis in relation to the medical needs and not to exceed six months ahead, beginning with the month in which the medical service was rendered. Six months is the maximum time period in which income can be considered available for meeting medical care costs."

34/ The six-month provision for computation of income of the medically needy for spenddown purposes has been maintained throughout the entire history of the regulation. See 36 Fed. Reg. 3860

(footnote continued)

Pursuant in turn to this federal regulation, twenty-eight states[35/] and the District of Columbia have chosen to participate, and for twenty years states have participated, in the medically needy program using a spenddown period in excess of one month (in most, of six months). In each case, the Secretary has approved the State plan so providing. Cf. R. 161 (re HHS review of State plans).

(footnote continued)

(Feb. 27, 1971), codified at 45 C.F.R. § 248.21(3)(iv); 39 Fed. Reg. 9517 (March 11, 1974), deleting the three-month provision and transferring the regulation to 45 C.F.R. § 248.3(c)(4); 42 Fed. Reg. 52827 (Sept. 30, 1977), redesignating 45 C.F.R. Part 248 as Part 448; 43 Fed. Reg. 45176, 45177 (Sept. 29, 1978), transferring 45 C.F.R. § 448.3(c)(4) to 42 C.F.R. § 435.831 insofar as it concerned income eligibility; 45 Fed. Reg. 24886 (Apr. 11, 1980), amending 42 C.F.R. § 435.831.

35/ Including five new states subsequent to TEFRA, see n. 29, supra, but excluding Illinois, see n. 26, supra.

The Secretary's consistent interpretation over the twenty-year life of Medicaid is entitled, at a minimum, to "substantial deference" by reviewing courts. Connecticut Department of Income Maintenance v. Heckler, ___ U.S. ___, 105 S. Ct. 2210, 2215 (1985).[36/] Under this familiar standard, "the agency's construction need not be the only reasonable one in order to gain judicial approval." Id. The Secretary's interpretation of Title XIX as permitting a six-month spenddown for medically needy eligibility is clearly reasonable.

36/ See also, e.g., United States v. Riverside Bayview Homes, Inc., ___ U.S. ___, 106 S. Ct. 455, 461 (1985); Chevron, USA, Inc. v. Natural Resources Defense Council, Inc., 467 U.S. ___, 104 S.Ct. 2778, 2782-83 (1984); Norwegian Nitrogen Co. v. United States, 288 U.S. 294, 315 (1933) (opinion of Cardozo, J.).

Moreover, when made pursuant to an explicit delegation of substantive authority, as here, the Secretary's interpretation is entitled to legislative effect. Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. ___, 104 S. Ct. 2778, 2782 (1984); Herweg v. Ray, 455 U.S. 265, 274-75 (1982); Schweiker v. Gray Panthers, 453 U.S. 34, 43-44 (1981); Batterton v. Francis, 432 U.S. 416, 425-26 (1977). Under that standard, the regulation must be given controlling weight unless it is either arbitrary and capricious or beyond the Secretary's statutory authority, Gray Panthers, supra, 453 U.S. at 44, which it clearly is not.

The court below, in striking violation of these principles, acknowledged the argument, Pet. A23-A24, and then pro-

ceeded to totally ignore the Secretary's regulation. Pet. A24-26. By contrast, the First and Second Circuits recognized these important principles governing judicial construction of federal statutes, and applied them accurately to the present context by according deference to the Secretary's regulation. DeJesus v. Perales, 770 F.2d at 327; Hogan v. Heckler, 769 F.2d at 888, 892 and n. 12, 896-97, 902.[37/]

As in Connecticut Department of Income Maintenance, supra, in this case "Congress has never indicated dissatisfaction with the Secretary's undeviating

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37/ See also Williams v. St. Clair, 610 F.2d 1244, 1248-49 (5th Cir. 1980) (deferring to Secretary's spenddown regulations in a § 209(b) context, even though 42 U.S.C. § 1396a(f) lacks the express delegation of spenddown authority contained in § 1396a(a)(17)).

construction." 105 S. Ct. at 2215. In enacting TEFRA, Congress addressed itself to the very subpart in which the Secretary's authorization at issue is found, and corrected other regulations, but "reaffirmed" this one. This is further evidence that the Secretary has not exceeded his authority in promulgating the regulation and that it is neither arbitrary and capricious nor manifestly contrary to the statute but instead is a reasonable interpretation of Title XIX. It follows that the regulation entitled to controlling weight in this case and that Massachusetts' use of a six-month spend-down under its authority is valid.

D. The Six-Month Spenddown Was Never in Conflict With, But Was in Fact Authorized by the Secretary Pursuant To, 42 U.S.C. § 1396a(a)(17).

Nor were the Secretary's regulation and Massachusetts' practice contrary to the "comparability" requirement of 42 U.S.C. § 1396a(a)(17) even before TEFRA, as the complaint alleges. Although the court below did not address the point, it may be raised in support of the judgment. The Second Circuit saw "little force" to the contention in DeJesus v. Perales, 770 F.2d 316, 323 (2d Cir. 1985), and it was rejected after a comprehensive inquiry in Hogan v. Heckler, 769 F.2d 886, 891 et seq. (1st Cir. 1985).38/

38/ The plaintiffs in DeJesus v. Perales, 770 F.2d at 323, n. 9 and in Hogan v. Heckler, 769 F.2d at 893-94,

(footnote continued)

In fact, the income standard com-

(footnote continued)

recognized that the Secretary's regulation was valid for 15 years (1966 to 1981), but argued that OBRA's adoption of one-month budget periods for AFDC and SSI invalidated it. In fact, however, prior to OBRA, SSI was calculated on a quarterly basis in all states, see P.L. 92-603, § 301, 86 Stat. 1466 (thereby mandating a three-month spenddown for SSI-related medically needy applicants under respondents' theory), and "throughout the period during which the Secretary's regulation permitting a six-month spend-down has been in force, eligibility for AFDC has been determined by calculating income on a monthly basis." DeJesus v. Perales, 770 F.2d at 323 n. 9; see 42 U.S.C. §§ 602(a)(8), (28) (1976 ed.). The purpose of the OBRA changes was to reduce overpayments by requiring retrospective budgeting and monthly reporting, S. Rep. No. 139, 97th Cong., 1st Sess. 516-17 (1981), which was intended to contract, not expand, the social welfare budget by millions of dollars annually, and the legislative history belies any congressional intention to override the widespread use of six-month spenddowns. "Had Congress meant to invalidate all these state programs plus the Secretary's longstanding regulation, it hardly would have done so through the indirect method

(footnote continued)

parability provision of § 1396a(a)(17) is irrelevant to the spenddown calculation. Section 1396a(a)(17) requires that the State use "reasonable standards" for determining income and resource eligibility and the extent of medical assistance. It is those standards "which shall be comparable for all groups." The same section provides for flexibility in the application of such standards with respect to income by taking into account, "except to the extent prescribed by the Secretary," costs incurred for medical

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of an amendment to the SSI and AFDC requirements alone, without any reference whatever to the medically needy." Hogan v. Heckler, 769 F.2d 886, 896 (1st Cir. 1985). Nor would it have reaffirmed the regulation the following year. See pp. 46, 49-50, supra.

and remedial care.[39] That spenddown calculation is unique to the medically needy who, unlike the categorically needy, have income in excess of the standard.[40]

39/ It is noteworthy that when describing the operation of the spenddown concept in 1965, Congress used annual figures. H.R. Rep. No. 213, 89th Cong., 1st Sess. 68 (1965); Cong. Rec., 89th Cong., 1st Sess. S15876 (July 8, 1965) (remarks of Senator McNamara, the bill's cosponsor in the Senate).

40/ Moreover, it is the petitioner's position that the general comparability provision of § 1396a(a)(17) does not extend to comparability between the categorically and the medically needy. The legislative history of the Social Security Amendments of 1965, which inserted this requirement (79 Stat. at 346) evidences instead a concern for comparability among the various categorical groups of needy people. S. Rep. No. 404, 89th Cong., 1st Sess. 77, 78-79 (1965), reprinted in 1965 U.S. Code Cong. & Admin News 1943, 2017, 2018-19; H.R. Rep. No. 213, 89th Cong., 1st Sess. 66-67 (1965). See R. Stevens & R. Stevens, Welfare Medicine in America (1974) 63. This

(footnote continued)

The Secretary, whose regulations in many other respects have adopted quite a broad reading of comparability, has consistently taken the position that the length of the spenddown used for medically needy eligibility need not be the same as the budget period for the applicable categorical program. And this Court also has recently cautioned that the comparability provisions of §§ 1396a(a)(10) and (17), whatever their scope, "did not require that the medically needy be treated comparably to the categorically needy in all respects."

(footnote continued)

Court recognized as much in Schweiker v. Hogan, 457 U.S. 569, 574, n. 6 (1982). However, some courts have adopted a broader interpretation, see id. at 587, n. 28. As in Schweiker v. Hogan, this broad issue need not be reached.

Schweiker v. Hogan, 457 U.S. at 587. The present context involves one of the salient respects in which the medically needy are required to be treated differently from the categorically needy -- by virtue of § 1396a(a)(17) itself. Those individuals receiving cash assistance under AFDC or SSI are eligible for Medicaid automatically, and the spenddown provision of § 1396a(a)(17) has no application to them. See Fullington v. Shea, 320 F. Supp. 500 (D. Colo. 1970), aff'd summarily, 404 U.S. 963 (1971). The plaintiff class is eligible for Medicaid only by virtue of a flexible accounting for medical costs which has no counterpart in the underlying categorical programs. In choosing to extend Medicaid coverage to medically needy groups through offsetting their excess income

with medical expense, Massachusetts is engaging in a procedure which is unique to its medically needy applicants. Judge Friendly expressed the point aptly and succinctly:

> [S]ince the very purpose of § 1396a(a)(17) is to regulate the standards under which persons having incomes higher than allowed in the cash assistance programs may still qualify for Medicaid, it cannot be read to require that the standards must be the same as those in the cash assistance programs in all respects. The direction is that the standards shall be "comparable," not identical, for all groups. Comparison invites an examination of differences as well as resemblances. . . . Read together, the requirements of "comparability" and "flexibility" imposed by § 1396a(a)(17) simply do not mandate the rigidly identical treatment of categorically and medically needy Medicaid recipients for which plaintiff contends.

DeJesus v. Perales, 770 F.2d 316, at 324 (2d Cir. 1985). In short, there was

never any serious doubt under § 1396a(a)-(17) that the six-month spenddown, which is sanctioned by HHS under the authority of § 1396a(a)(17) itself, was valid.[41/]

41/ In addition, one specific concern of the 90th Congress, which amended Title XIX to place a limit upon the level of the income standard which a state could adopt subject to federal financial participation, P.L. 90-248, § 220(a), adding 42 U.S.C. § 1396b(f), was that high medically needy income standards would lead individuals to forego insurance. Schweiker v. Hogan, 457 U.S. at 577-78 (quoting H.R. Rep. No. 544, 90th Cong., 1st Sess. 118 (1967)). Granting the remedy sought by the respondents here would create a disincentive for employers to offer, and employees to seek, health insurance coverage. A likely result of a one-month spenddown policy would be a form of financial planning whereby routine medical treatments would be scheduled in the same month so as to reduce one's own financial liability, rather than scheduling such appointments over a more manageable period. It is entirely possible, if not predictable, that individuals aware of the possibility of a one-month spenddown would become self-insurers, bypassing available private insurance with the knowledge that Medicaid coverage would be available for high-expense months.

CONCLUSION

For the reasons stated above, the decision below should be reversed.

Respectfully submitted,

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January, 1986

APPENDIX

42 U.S.C. § 1396a(a)(10) (1982 ed.)

Section 1396a(a)(10) of Title 42 of the United States Code, as amended by the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248, provides in pertinent part as follows:

42 U.S.C. § 1396a(a). A State plan for medical assistance must--

* * *

(10) provide--

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title, to--

(i) all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter,

or part A or part E of subchapter IV of this chapter (including pregnant women deemed by the State to be receiving such aid as authorized in section 606(g) of this title and individuals considered by the State to be receiving such aid as authorized under section 614(g) of this title), or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter; and

(ii) at the option of the State, to any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but--

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;

(V) who are in a medical institution, who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit

established under section 1396b(f)(4)(C) of this title, or

(VI) who would be eligible under the State plan under this title if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in section 1396n(c) of this title they would require the level of care provided in a hospital, skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under section 1396n(c) of this title;

(B) that the medical assistance made available to any individual described in subparagraph (A)--

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A), then--

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical

assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance--

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

* * *

42 U.S.C. § 1396a(a)(17) (1982 ed.)

42 U.S.C. § 1396a(a). A State plan for medical assistance must--

* * *

(17) include reasonable standards (which shall be comparable for all groups and may in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent

of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evalua-

tion of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance prem-

iums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

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Assistance Administration

Supplement D

Medical Assistance Programs

D-4200 Financial Eligibiity 6/17/66

D-4220. Requirements for State Plan

A. A State plan for medical assistance, if it includes the medically needy (see D-4000), must:

1. Provide levels of income and resources for maintenance, in total dollar amounts, as a basis for establishing financial eligibility for medical assistance, in accordance with the following:

a. Such income levels must be comparable as among individuals and families of varying sizes.

* * *

2. Provide that there will be a flexible measurement of available income which will be applied in the following order of priority:

* * *

3. Provide that all income and resources (after all State policies governing that disregard, or setting aside for future needs, of income and resources in the States approved plans under titles I, IV, X, XIV, and XVI, have been applied) will be considered in establishing eligibility, and in the flexible application of income to medical costs not in the State plan, and payment toward the medical assistance costs.

4. Provide that only such income and resources as are actually available will be considered; that income and resources will be reasonably evaluated; and that only such income and resources will be considered as will be "in hand" within a period, preferably of not more than three months, but not in excess of six months, ahead, including the month in which medical services were rendered for which payment would be made under the plan.

5. Provide that financial responsibility of any individual for any applicant or recipient of medical assistance will be limited to the responsibility of spouse for spouse and of parents

for children under age 21, or blind, or permanently and totally disabled; and specify the extent to which the financial responsibility of any such relatives is taken into account.

42 C.F.R. § 435.831 (1985)

§ 435.831 Income eligibility.

The agency must determine income eligibility of medically needy individuals in accordance with this section. The agency must use a prospective period of not more than 6 months to compute income.

(a) Determining countable income. The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(2) For aged, blind, or disabled individuals in States covering all SSI recipients, the agency must deduct

amounts that would be deducted in determining eligibility under SSI. However, the agency must also deduct the highest amounts from income that would be deducted in determining eligibility for optional State supplements if these supplements are paid to all individuals who are receiving SSI or would be eligible for SSI except for their income.

(3) For aged, blind, or disabled individuals in States using income requirements more restrictive than SSI, the agency must deduct amounts that are no more restrictive than those used under the Medicaid plan on January 1, 1972 and no more liberal than those deducted in determining eligibility under SSI or an optional State supplement. However, the amounts must be at least the same as those that would be deducted in determin-

ing eligibility, under § 435.121, of the categorically needy.

(b) Eligibility based on countable income. If countable income determined under paragraph (a) of this section is equal to or less than the applicable income standard under § 435.814, the individual or family is eligible for Medicaid.

(c) Deduction of incurred medical expenses. (1) If countable income exceeds the income standard, the agency must deduct from income, in the following order, incurred medical expenses that are not subject to payment by a third party:

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges, incurred by the individual or family or financially responsible relatives, including enrollment fees,

copayments, or deductibles imposed under § 447.51 or §447.53 of this subchapter.

(ii) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan.

(iii) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan.

(2) The agency may set reasonable limits on the amounts of incurred medical expenses to be deducted from income under paragraphs (c)(1)(i) and (ii) of this section.

(d) Eligibility based on incurred medical expenses. Once deduction of incurred medical expenses reduces income

to the income standard, the individual is eligible for Medicaid.

Massachusetts General Laws

Chapter 118E, § 10 (1984 ed.)

The fourth unnumbered paragraph of section 10 of chapter 118E of the Massachusetts General Laws, as inserted by Mass. Stat. 1969, c. 800, § 1, provides as follows:

§ 10.

* * *

In any case where the monthly income of a recipient or beneficiary is in excess of the exemptions allowed, the recipient or beneficiary shall be liable to pay to the provider of medical care or service an amount which shall be equal to the excess income for a period of six consecutive months, which includes the period when such service was provided.

* * *

106 Code Massachusetts Regulations

§ 506.400: MA Income Standards

The MA Income Standards are the standards of need established by the Department and used for the determination of financial eligibility.

Eligibility shall be established for an otherwise eligible individual whose Net MA Income is equal to or less than the applicable MA Standard. If Net MA Income is greater than the MA Income Standard, eligibility may be established on the basis of the spenddown provisions.

§ 506.510: The Spend-Down Period

The spend-down period is a six (6) month prospective period which starts on the first day of the month of service of the earliest bill used to meet the spend-down amount. This date shall not be earlier than three (3) months prior to

the month of application and shall not extend more than six months from the first day of application.

§ 506.520: Calculating the Spend-Down Liability

The spend-down liability is the amount of excess income that the applicant or recipient is considered to have available to meet medical expenses during the spend-down period.

The amount by which the Net MA Income exceeds the MA Income Standards is the excess monthly income. The spend-down liability is determined by multiplying the excess monthly income by six.

§ 506.570: Conclusion of the Spend-Down Process

When bills submitted are equal to or greater than the spend-down liability

and all other eligibility requirements continue to be met, the applicant shall be notified that he is eligible. The recipient is eligible for payment of all covered medical expenses incurred during that spend-down period, other than those submmitted to meet the spend-down liability, as long as all other eligibility requirements continue to be met during the balance of the spend-down period.